Psychological Monographs

General and Applied

No. 372
1954

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Chicago, Illinois

Vol. 68
No. 1

Price, $1.00

Edited by Herbert S. Conrad

Published by The American Psychological Association, Inc.

Psychological Monographs: General and Applied

Combining the Psychological Monographs and the *Archives of Psychology*
Formerly the *Psychological Monographs*

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Vol. 68, No. 1 Whole No. 372, 1954

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Clients' Feelings and Attitudes in Relation to the Outcome of Client-Centered Therapy[1]

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I. INTRODUCTION

A. Purpose of the Study

In the decade that has elapsed since Rogers' *Counseling and Psychotherapy* (19) was first published, considerable understanding has been gained as to the nature of the process initiated by client-centered therapy. This understanding has come about principally as a consequence of the many and varied investigations of the content of the verbal interchange between client and counselor. The results of these investigations suggest strongly that the process set in motion by client-centered therapy is a predictable one, the characteristics of which lend themselves to observation and objective measurement.

While analysis of therapeutic protocols has proved to be highly fruitful, vast gaps remain to be filled before complete understanding of the treatment process and its effect upon the client can be achieved. Perplexing problems continue to arise, for example, as to why some individuals are better able to make effective use of client-centered therapy than others (16), why some individuals who are judged to show increased defensiveness in the course of their treatment show movement in other areas similar to that of clients manifesting diminished defensiveness (3), why the changes brought about by client-centered therapy seem to be of a more durable nature for some individuals than for others (4), etc. In short, the treatment process is still not sufficiently understood to be able to define properly the prerequisites for enduring successful therapeutic outcomes.

Inasmuch as the client plays the predominant role in the therapeutic interrelationship, it seemed pertinent to attempt to explore how *he* perceives and reacts to the treatment experience, to see whether or not viewing treatment *from the perceptual or phenomenological frame of reference of the client* can lead to fuller understanding of the meaning and impact of the therapeutic experience.

In recent years, several first-hand accounts have appeared in the literature which help shed light on the treatment relationship as experienced by the client. Some of these have been retrospective, set down after therapy was concluded (1,2,6,10,11, 23); others consist of personal notes made by the client following each interview (20, pp. 88-129).

[1] This study is a revision of a dissertation submitted in 1951 to the Committee on Human Development of the University of Chicago in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

A doctoral dissertation is always a group endeavor. The group of which this writer was a member consisted of Dr. Carl R. Rogers, Dr. Jules Seeman, Dr. Margaret Fox, and Mr. Bernard H. Gold. To all of these individuals the writer is indebted for their generous assistance with this study. To the nine individuals who participated in this research and who perforce remain anonymous the writer owes an especial debt for permitting him the rare privilege of sharing with them their private world of meaning and feeling.

Still another source of relevant data is to be found in the occasional comment made by the client in the course of his interviews with the counselor. However, while all of these have provided valuable information, the first type of data may be considered deficient in that it is generally written at some interval following completion of therapy; the second type is usually the product of a highly verbal, introspective individual; and the third type generally constitutes irregular, sporadic asides made by the occasional individual in treatment. There has not, then, to date been any systematic investigation of the way in which therapy is perceived and experienced by a random group of clients.

B. Hypothesis to be Tested

The current study was undertaken in an attempt to drive another and perhaps more insistent wedge into this meagerly explored area. It is based on the hypothesis that *the patterns of feelings which the client holds toward himself, the patterns of attitudes which he exhibits toward the therapist, and his perception of the treatment process bear a relationship to eventual outcome of therapy.*

The procedures used in this research will be described in detail in the next chapter, but it might be well to state at this point that the basic plan involved analysis of the feelings and attitudes which a group of nine clients expressed relative to self, counselor, and process in ten-minute recordings routinely made by these clients directly following each treatment interview. The findings which emerged were then related to an independent estimate of the extent of change which each of these clients sustained as a consequence of his experience in treatment. No attempt was made to analyze the contents of the interviews themselves, since it had been anticipated that they would not yield a systematic account of the clients' perception of, and reaction to, the treatment experience.

It is to be noted that the investigator also served as the therapist for all of these clients. He felt secure in taking on this dual role for three main reasons: (*a*) this study was not intended to test his therapeutic competence, (*b*) the investigation was undertaken without prejudice, in full expectation that the client statements themselves would dictate the course of the inquiry into the data, and (*c*) the data were not to be examined or analyzed until all clients in the research group had terminated therapy. It was also expected that the clients under study would accept and virtually forget the fact that the therapist planned to study their postinterview comments experimentally after therapy was concluded, so that the therapeutic process would not be impeded or delayed.

In brief, then, the investigator went directly to the client to obtain the data for the present research. There are no doubt many who would object to this procedure. Hathaway (5, p. 227) would contend that it is naive to assume that the client can feel free to be frankly critical. Smith would consider it inadequately scientific "to take the phenomenal world presented in conscious experience as completely explanatory of behavior" (24, p. 517). In regard to the former, it is the belief of this writer that candid reports can be obtained from clients when the circumstances surrounding the eliciting of these reports are sufficiently permissive. Regarding the latter, it is believed here that the client's reaction to and behavior in therapy are functions of his *perception* of the field. Further, while the writer recognized that subjective reports deal only with material which is present in awareness and which can be verbalized, it is obvious that "verbal behavior is just as truly behavior as any other sort of action, and therefore, whether or not the patient is conscious or unconscious of its significance, changes in its characteristics can be observed and measured" (15, p. 127).

II. DESIGN AND PROCEDURES OF THE STUDY

A. Subjects

At the time of inception of this study, the investigator was attached to a Veterans Administration guidance center as a personal counselor. His counselees were all veterans who originally came to the center because of a vocational or scholastic problem and were subsequently referred for counseling service by their vocational adviser.

Twelve routinely referred veterans were invited to participate in this experiment. Cooperation in this research was not made a condition of treatment, and it was made clear to each individual that collaboration in this project would have no relationship to the actual therapeutic process as such. A complete description of what would be required of him was provided for the client so that he was thoroughly familiarized with the experimental procedures before he decided whether or not he wished to be part of the research group.

Out of the 12 cases originally approached, all expressed willingness to participate in the study. Only nine were eventually used, however, since only nine met the investigator's requirement of coming in for a minimum of five counseling sessions. Of the remaining three, one returned to an out-of-town college following his second interview; one, following his third interview, secured employment, which prevented his returning to treatment; and the third was still in treatment when the guidance center closed down. This last case was therefore not completed.

At the time treatment began, little was known about the individuals who were to comprise the research group except that each was a male veteran of World War II and each had initially come to the guidance center seeking help with a vocational or scholastic problem.

B. Experimental Design

1. The first step, following the client's decision to participate in the experiment and before starting treatment, was the administration of the Thematic Apperception Test.[2] The test was uniformly administered to each subject by the experimenter. The protocols, which were recorded electrically, were deliberately not transcribed or evaluated until all clients in the research group had concluded therapy, to avoid the possibility that the therapist might consciously or otherwise stimulate the client to discuss material brought to light in the test record but which the client might perhaps not wish or need to discuss in the course of his treatment interviews.

2. Following administration of the pretherapy TAT, each client was counseled by means of client-centered therapy in interview sessions consisting of 50 minutes each. (These interviews were *not* subjected to analysis.)

3. Upon completion of each session, the client was given ten minutes in which to discuss the following standard question:

"Describe your feelings about what, if anything, has gone on in this hour, and your feelings about yourself and the counselor during the hour."

The question posed to these clients was deliberately loosely structured. It was designed to permit each subject to be unique in his handling of the situation by relating to the question as he wished, thereby revealing those issues that were of central significance to him as an individual.

The counselor was not present when the client discussed the question. The client's response was recorded on a separate disc (herein referred to as his *postinterview recording*), apart from the regular interview content, and the client was told that his postinterview recordings would not be played back or subjected to analysis until the treatment relationship had been terminated by all the individuals involved in the study. The client was instructed to take for his discussion as much of the remainder of the hour as he saw fit. For purposes of consistency and to facilitate his addition of further comments following a pause, he was also requested not to leave the interviewing room and not to turn off the recording apparatus until the counselor returned when the ten minutes were over.

4. When the client voluntarily indicated a desire to terminate counseling, arrangements were made for the administration of a posttherapy TAT during a subsequent meeting. The retest was again uniformly administered by the experimenter, and the protocols were recorded electrically.

5. The last step, following the client's decision to terminate, was a *final focused interview* (14), the purpose of which was to provide an overview of the client's experience in treatment. It was so structured as to obtain from the client the meaning of his treatment experience to him, all rememberable conscious aspects of his behavior and functioning while in therapy, his feelings and attitudes toward self, counselor, and

[2] Cards 1, 2, 3BM, 4, 6BM, 7BM, 8BM, 14, 17BM, and 19 (Harvard University Press, 3rd Edition) were used. These ten cards were selected on the ground that they had been and were being used successfully in studies of male adults for the purpose of personnel selection.

process, from the first through the last sessions, and the reasons for any changes in his feelings and attitudes, as he saw them.

The final focused interviews were all conducted by a second clinician who was given a broad, general outline setting forth the principal areas of inquiry. An outsider was introduced at this point in order to permit the client to be as frank and as critical as he might wish in discussing his subjective experience in treatment. While it was recognized that some clients might have difficulty in communicating with someone new and unfamiliar to them, it was felt that this procedure should be employed to keep the client comments as free as possible from any influence that might be generated by the counselor's presence or his bias.

C. The Data Analyzed

The nine cases studied had a total of 120 interviews. The shortest in length was five interviews; the longest was 25.[3]

In brief then, the total data analyzed consist of: (*a*) nine pre- and nine post-therapy TAT's, (*b*) 120 ten-minute post-interview recordings, and (*c*) nine final focused interviews. The TAT protocols were used to provide an index of the extent of change each client sustained as a consequence of his experience in treatment; the ten-minute postinterview recordings were systematically analyzed through the use of categories designed to reveal "the patterns of feelings which the client exhibited toward self, counselor, and process" as he went through treatment; and the final focused interview material was used to complement the information derived from the ten-minute postinterview recordings, to shed light on the basis for the client's feelings and attitudes, and to provide a graphic overview of the client's experience in treatment.

D. The Categories Applied

Nine categories were developed for application to the client postinterview recordings. Three of these tapped the client's feelings and attitudes relative to self, counselor, and process, as demanded for the testing of the hypothesis. The remaining categories emerged from the material itself and deal with various facets of the treatment situation about which the clients under study apparently had a need to express themselves. These six remaining categories were adopted for use not only because they cover an array of elements with which the clients themselves seemed concerned, but also because they appeared to have definite pertinence in terms of the central problem under study. The nine categories used were:

1. Current perception of self and feelings associated with current perception of self;
2. Past perception of self and feelings associated with past perception of self;
3. Feelings and attitudes in relation to counselor;
4. Feelings and attitudes in relation to process;
5. Feelings and attitudes in relation to sharing and confiding;
6. Feeling tone during hour;
7. Feeling tone outside hour;
8. Anticipation of outcome;
9. Insight, consisting of:
   a. Insight and self-understanding;
   b. Insight into the nature of the process;
   c. Planning and working out solutions.

For the most part, these were *feeling* categories—categories which referred to the feelings and attitudes expressed in the client remarks. They were designed to show change in either direction or intensity of affect, and also to disclose change in the frequency with which the client comments lent themselves to classification in each category, from recording to recording. Change in direction means change from feelings of approval to disapproval, discomfort to comfort, etc. Change in intensity means change from dislike to stronger dislike, tension to diminishing tension, etc.

By and large, the client comments were scored as either positive, ambiva-

[3] The mean number of interviews was 14.4.

lent, or negative. Additional subclassifications for each category were also developed as need for them was suggested by the contents of the client documents. The complete list of categories, definitions of the subheadings falling under each category, and examples of client remarks that might be classified under these various subheadings are presented below.

E. The Categorization System

Current and Past Perception of Self and Feelings Associated with Perception of Self

A major purpose of this experiment was the investigation of the relationship that existed between the extent of change which the client sustained, as measured by the TAT, and the patterns of feelings which he exhibited toward himself in the course of his treatment experience. As seen here, the client's feelings toward self involve: (*a*) a perception by the client of himself, and (*b*) a reaction by the client to that which he sees in himself. Although the experimenter was primarily interested in the patterns of *feelings* which the client manifested toward self, it was decided that how the client perceived himself should also be observed and measured since change in self-concept is generally considered to be associated with successful therapy.

In classifying the client's comments as to how he perceived himself, each comment was first rated for direction before notation was made as to whether or not his remark seemed to have affective value for him. Direction was in terms of *positive, negative, ambivalent,* or *confused* self-perception. Under "positive" were classified all comments in which the client gave evidence of an approving or favoring attitude toward self; "negative" consisted of disapproving or rejecting self-attitudes or self-evaluations; under "ambivalent" were classified all comments showing simultaneous presence of positive and negative self-perception or conflicting attitudes toward self; and "confused" perception of self covered those comments in which the client gave evidence either of being confused in his self-evaluation or inability to understand himself, his thoughts, feelings, or conduct.

Examples:

Positive: "I've always considered myself a generous person."

Negative: "I guess I never have known how to make friends."

Ambivalent: "At times I do think I'm kind of cold . . . but still I've never turned down a request for a favor."

Confused: "As time goes on, I become more and more unsure as to what kind of person I really am."[4]

The feeling or affective value of each self-referential remark was originally estimated on a three-point continuum (positive, neutral, or negative). However, since a trial run through the documents showed no instance in which a client seemed to have negative feeling associated with a positive self-perception or positive feeling with respect to a negative self-perception, it was decided that only presence or absence of affect be noted. Self-referential comments which appeared to have emotional value for the client were therefore rated as affect-laden; those which seemed to be intellectual expressions or objective statements were scored as neutral or without affect.

Each self-evaluative comment was also classified for time. Comments referring to current self-perception were categorized as "current perception of self"; those which referred to past self-perception were classified separately as "past perception of self." While the writer was aware that the latter category did not permit distinction between the remote and the immediate past, between a reported concept of self operative prior to counseling and that which may have been operative in an earlier phase of counseling, this did not seem to be of import in terms of the current research.[5]

Feelings and Attitudes in Relation to Counselor

Most of the client comments relative to counselor were distinguished as either positive, negative, or ambivalent, connoting approving, disapproving, and conflicting attitudes, respectively. Two additional types of counselor references were found in the documents which lent themselves to classification under the subheadings "no feelings" and "fantasy." "No feelings" covered those instances where the client specifically stated that he had no feelings about the counselor; the "fantasy" classification caught all speculation on the part of the client about the personal life of the counselor, his background, likes and dislikes, etc. Inasmuch as it was usually difficult to ascertain from the manifest content of his remarks just what meaning his speculation about the counselor had for the client, all such remarks were classified under the general subheading of "fantasy" without endeavoring to infer how the client felt about about what he was saying.

[4] This statement would be classified as "increasing confusion."

[5] It subsequently developed that this category was omitted from the analysis of certain aspects of the data since there proved to be too few client comments classifiable in this category to warrant statistical study.

EXAMPLES:

Positive: "He seems to be a friendly sort of person."

Negative: "He looks like he's always had a nice, easy life . . . I never did like people like that."

Ambivalent: "He seems interested enough and it's good to talk to someone who *is* interested for a change . . . but that may be because he's paid to be interested."

No Feelings: "I don't feel one way or the other about him . . . I guess I never even gave it any thought."

Fantasy: "Well . . . I was wondering, for instance . . . if . . . about the counselor himself . . . I was wondering how his problems . . . if he didn't . . . if he had lots of problems to cope with . . if lots of things went haywire . . . if he was making as much money as he would like to make . . . if he found his occupation as satisfying as he would wish for."

Feelings and Attitudes in Relation to Process

Five types of reaction to "process" were found in the client documents: positive, negative, ambivalent, "confused," and "impatience with process." Again, positive, negative, and ambivalent feelings mean approval, disapproval, and conflicting feelings, respectively. Under "confused" were classified all remarks in which the client expressed either (*a*) bewilderment as to what he might expect from counseling, or (*b*) inability to comprehend his role and function and those of the counselor in their interrelationship; "impatience with process" covered all comments in which the client gave evidence of restlessness or uneasiness around the length of time required for reaching solution, implying that the working through of his difficulties involved a slower procedure than he had anticipated. Though it was recognized that feelings of "confusion" and feelings of "impatience" may sometimes be a manifestation of negative feelings, the distinction made here was intentional since confusion and impatience do not always connote disapproval in the same sense as do negative feelings.

EXAMPLES:

Positive: "And I believe that talking in this free manner . . . like I'm doing now . . . helps me better understand all the issues involved for me."

Negative: "I find that this is not leading anywhere . . . I came here for a solution . . . some advice . . . but it doesn't look like he's planning on giving me any . . . I may as well be talking to myself for all the benefit I get out of this."

Ambivalent: "Talking in this way seems to relieve me of some of the tension I had . . . but it doesn't help me work the basic problem out."

Confused: "I catch myself continually wondering why he says so little. Will he be giving me his analysis of my situation when I'm through talking? . . . Or do I go on talking forever this way?"

Impatience: "I wanted to be able to settle this thing . . . one way or another . . . before school starts again . . . At this rate, I'll never make it . . . This thing moves damn slow."

Feelings and Attitudes in Relation to Sharing and Confiding

By and large, the clients' expressions indicating how they felt about sharing with and confiding in the counselor lent themselves to scoring as either positive, negative, or ambivalent. A fourth classification, called "blocking," was devised, consisting of all comments which showed awareness or suspicion on the part of the client of either (*a*) the presence of inhibition in communicating with the counselor, or (*b*) lack of complete frankness, candor, or honesty on his part in talking with the counselor. Thus it consisted of all remarks in which the client indicated awareness or suspicion that one portion of the self was preventing his entering into full, open discussion of himself and his problems. The presence of "blocking" on an "unconscious" level or the presence of "blocking" which the client did not verbally recognize as such were not scored. Only those comments in which the client himself spontaneously reported awareness of withholding were classified, in order that all categories be consistently phenomenological. Increasing or diminishing "blocking" were also noted when reported by the client. While it was recognized by the experimenter that "blocking" or inability to share and confide is often indicative of a negative attitude toward sharing and confiding, it was decided that "blocking" items be classified separately in order to facilitate differentiation between negative attitudes reported and recognized as such by the client and those of which he was perhaps less acutely aware.

EXAMPLES:

Positive: "I have the feeling of wanting to tell him things that I don't ordinarily discuss with other people."

Negative: "I just don't care to have him or anyone else know too much about myself."

Ambivalent: "There's a certain amount of relief in telling someone what I think . . . once I'm through talking . . . but it makes me damn uncomfortable while I'm doing the telling . . . particularly since I never know what he thinks about all this."

Blocking: "It must be that I talk about all these other people and their problems be-

cause I don't really want to get to my own problem . . . Every time I start to talk about myself there seems to be a block on my thinking . . . and I seem to be reluctant to give out my thoughts . . . I feel that the things I should get out won't come out at present."

Current Personal Feeling Tone, During and Outside the Hour

As is implied in the category titles, "feeling tone during hour" refers to the client's mood or frame of mind during the 50-minute sessions which he spent with the therapist and "feeling tone outside hour" covers his mood, frame of mind, or feeling tone between sessions.

Based on the contents of the client documents, five subheadings were devised for both "feeling tone" categories: (*a*) "positive," indicating that the client was comfortable and at ease with himself, that the self was feeling expansive; (*b*) "negative," indicating that the self felt constricted, heavy, oppressed, burdened, or that the client was experiencing personal discomfort, strain, distress, anxiety, etc.; (*c*) feelings of "uncertainty," consisting of those remarks in which the client indicated that his mood, frame of mind, or feeling tone were undefined or unidentifiable by him; (*d*) "apathy," covering those comments in which the client reported absence or lack of feeling, that his feeling tone was a neutral or indifferent one; and (*e*) feelings of "sameness," implying no change.

EXAMPLES:

Positive: "I feel comfortable now . . . at peace with the world."

Negative: "This probing in my mind sure makes me jumpy . . . all keyed up."

Uncertainty: "I don't quite know how I feel right now."

Apathy: "Maybe I'm just worn out . . . Anyhow I don't seem to react anymore . . . I don't seem to care one way or the other."

Sameness: "I don't feel any different . . . even after telling all this."

Anticipation of Outcome

Client comments classified in this category were rated as either positive, negative, or ambivalent. Under "positive" were scored all comments in which the client expressed faith that therapy would be of help to him or in which he predicted satisfaction with the results of his experience in treatment; under "negative" were classified all comments in which the client demonstrated lack of confidence or in which he anticipated that he would be displeased with the results of his experience in treatment; and the "ambivalent" classification consisted of all remarks in which the client gave evidence of having conflicting feelings as to how therapy would turn out or in which he spoke of being uncertain as to whether or not he would be satisfied with the end results.

EXAMPLES:

Positive: "After this first meeting, it looks as if I can be helped here to overcome these feelings I have."

Negative: "I can't see where talking about all these other things is going to help me get along better on the job. As a matter of fact, I don't believe it will . . . and I can't help thinking I'm wasting my time here."

Ambivalent: "I feel a certain amount of relief . . . just talking . . . and that sure is a help . . . but I'm not sure that alone will turn the trick."

Insight

The "insight" category, as used here, covers three types of expressions often found in the client documents: (*a*) those which showed that the client had achieved new learning about himself, (*b*) those in which he evidenced understanding of the treatment process, and (*c*) those in which he described the steps he planned to take in order to reach solution. The experimenter saw fit to classify these expressions on the grounds that they cannot justifiably be ignored in any attempt to investigate what the client has gained from therapy and what meaning therapy has for him, from his own internal frame of reference.

The three aforementioned types of client expressions were scored and quantified separately under subheadings herein called "insight and self-understanding," "insight into the nature of the process," and "planning and working out solutions." The range of these subclassifications is presented below.

1. *Insight and self-understanding.* Under this subheading were tabulated all comments which indicated that the client had achieved a new, more differentiated manner of perceiving and observing, that one or more of the following were now present:

a. Understanding, clarity, or recognition on the part of the client as to how he felt about certain people, things, or situations. EXAMPLE: "I can see now that I never really wanted to go to school."

b. Ability to discern patterns or relationships in the material under discussion. EXAMPLE: "So it turns out that I always have that same reaction when I'm in a supervisory position . . . I feel so guilty every time I have to ask someone to do something that I wind up trying to do everything myself."

c. Awareness of motivation, the basis for his feelings, thoughts, or actions. EXAMPLE: "I guess it's because I'm afraid of getting hurt myself

that I can't say no to anybody . . . even when I should."

2. *Insight into the nature of the process.* Client comments were classified under this subheading which showed one or more of the following:

a. Understanding what the purposes of the specific counseling procedures are and how to permit the process to flow freely. EXAMPLE: "What happens is that you talk and you work out your own plans . . . and I guess it's purposely done that way 'cause then the plan is yours . . . and you're more apt to stick with it than if he mapped it all out for you."

b. Recognition of how the process functions to make possible fuller self-understanding. EXAMPLE: "So . . . as I talk, more and more ideas pop up in my mind . . . and it's the talking that does it."

c. Realistic or objective evaluation on the part of the client of the nature of his own feelings or behavior relative to the counselor or the counseling process, and of how these were either enhancing or hindering his treatment. EXAMPLE: "I guess if I had more faith in this . . . I'd put some thought into it . . . and then I'd probably get more out of my hour."

3. *Planning and working out solutions.* This last classification included all comments which referred to either:

a. A plan of action which the client anticipated or hoped would be of help in reaching solution, improved adjustment, or improved status. EXAMPLE: "I can't sit back any longer and wait for a promotion to fall in my lap . . . I'll just have to start working on it . . . and if I don't work for it, I guess I have no right to grumble if somebody else gets it."

b. A plan for amplifying or following through on insights achieved or a plan for taking new action for purposes of concretizing the insights achieved.[8] EXAMPLE: "So knowing what I now know about myself, I'll look for a job in a firm that's small and where I don't get the feeling of being lost in the shuffle."

F. The Basic Unit

Before proceeding with the scoring of the client comments, it was necessary to define what was to constitute a unit.

[8] While insight may not always be involved in an immediately observable manner in "planning and working out solutions," it was believed that this classification belonged in the general "insight" category on the premise that the reorganization process set in motion by therapy and as evidenced by new planning is grounded in a reorientation of the individual to himself and his situation.

TABLE 1

CATEGORIES USED TO ANALYZE THE CLIENT POSTINTERVIEW RECORDINGS*

Category	Classification of Response
1. Current perception of self	Positive*† Negative*† Ambivalent† Confused*†
2. Past perception of self	Same as for category 1
3. Feelings and attitudes re counselor	Positive* Negative* Ambivalent No feelings Fantasy
4. Feelings and attitudes re process	Positive* Negative* Ambivalent Confused* Impatience*
5. Feelings and attitudes re sharing and confiding	Positive* Negative* Ambivalent Blocking*
6. Anticipation of outcome	Positive* Negative* Ambivalent
7. Feeling tone during hour	Positive* Negative* Uncertainty* Apathy Sameness
8. Feeling tone outside hour	Same as for category 7
9. Insight	Insight and self-understanding Insight into the nature of the process Planning and working out solutions

* Client comments classified under this subheading were also rated for increasing or decreasing intensity.

† Each response also classified as carrying "affect" or "no affect."

After considerable examination of the documents, it was decided that the phrase be adopted as the basic unit for purposes of this analysis. Each phrase was also to be classified in as many differ-

ent categories as its nature warranted, as shown in Table 1.

G. Evaluation of the Reliability of the Means of Analysis

To test the objectivity and reliability of the classification system devised, 12 (10 per cent) of the postinterview recordings were analyzed independently by two judges. The recordings used in the interjudge reliability test were selected at random. The investigator himself served as the first judge (A). The second judge (B) had no prior knowledge of the experiment undertaken by the investigator and therefore required training.

The training program consisted of: (*a*) familiarization of Judge B with the purposes of the current study and the means of analysis of the postinterview recordings, (*b*) trial application by Judge B of the means of analysis, and (*c*) a series of conferences between judges during which differences in interpretation were discussed and a common frame of reference was arrived at.[7]

Working separately, Judge B and the investigator then went through the typescripts of the 12 postinterview recordings and scored them in terms of the nine categories. Both determined independently the number of elements they found in the client remarks and the direction and intensity of the feeling or attitude involved. Both set down the line of the typescript where they had judged each element to be in evidence so that specific comparisons could later be made by the experimenter.

It should be noted that no attempt was made by the experimenter to divide the client comments into units to be scored by the second judge, no clues were provided as to the categories in which their comments might lend themselves to classification, nor was the second judge's attention directed to any specific client comments. Instead, Judge B was given complete freedom to decide into which categories, if any, the client comments might be classified and the direction and intensity of the feelings and attitudes expressed.

Statistical procedures used to measure interjudge reliability. When the scoring process was completed by both Judge B and the investigator, the results were set up in tabular form, category by category, in the manner shown in Table 2.

Interjudge comparisons were made on a line-by-line basis and all similarities and differences in classification were noted. The percentage of agreement between judges was computed by applying the following formula to each table:

$$\text{Percentage Agreement} = 1 - \frac{\Sigma(a + b + c) \text{ or total number of differences}}{\text{total number of items classified identically}}$$

Results. There proved to be 100 per cent agreement between Judge B and the investigator in their scoring of the category "anticipation of outcome." This means that both independently identified the same items within the client comments to be classified into this category, and they rated them identically as to the direction and intensity of the feeling expressed. The lowest percentage of agreement was 81.9, in the category called "past perception of self." The over-all percentage of agreement was 94.4. This figure was secured by subtracting from unity the quotient derived by dividing the total number of differences in all categories by the total number of items classified identically in all categories. In no instance did the investigator and Judge B differ as to the direction of the feeling or attitude expressed by the client; in seven instances, they differed with respect to the intensity of the feeling or attitude involved in the client comments; and in 30 instances, items were identified as classifiable into the

[7] Where disagreement took place, it was found that this was usually the consequence of failure on the part of either Judge B or the investigator to adhere strictly to the definitions prepared rather than the consequence of ambiguity inherent in the definitions.

TABLE 2

SPECIMEN TABULATION OF DATA FOR DETERMINING INTERJUDGE AGREEMENT

Case	Judge A	Judge B	# Items Scored Identically	Differences		
				Same Direction, Difference in Intensity (*a*)	Difference in Direction (*b*)	# Items Scored by 1 Judge Only (*c*)
Davis						
White						
Robbins						
Walker						
etc.						

categories by one judge only. It was therefore this latter type of event that constituted the bulk of the disagreement.

After an interval of four months, the investigator repeated the judging process, rescoring the same 12 client recordings. Comparisons between his two sets of classifications were then made in the same manner as when his first classifications were compared with those of Judge B.

The lowest percentage of agreement between the investigator's first judgments and his second was 86.7; there were three areas in which his scorings were identical for both runs. The over-all percentage of agreement between his two scorings was 94.1. There proved therefore to be as much agreement and as much disagreement in the rescoring of the investigator as there had been between his first scoring and that of Judge B. The results of

TABLE 3

RELIABILITY OF SELECTION AND RATING OF CLIENT COMMENTS IN THE CATEGORIES*

Category	Judges A_1B		Judges A_1A_2	
	Percentage Agreement	*N*†	Percentage Agreement	*N*†
Current perception of self	96.2	109	89.4	114
Feelings associated with current self-perception	95.3	105	100.0	103
Past perception of self	81.9	13	86.7	17
Feelings associated with past self-perception	100.0	11	100.0	15
Feelings re counselor	94.9	81	96.2	79
Feelings re process	88.3	57	91.1	61
Feelings re sharing and confiding	95.8	73	97.4	73
Anticipation of outcome	100.0	23	100.0	23
Feeling tone during hour	93.7	50	91.4	50
Feeling tone outside hour	94.7	79	90.7	82
Insight				
Insight and self-understanding	96.2	54	94.3	55
Insight into the nature of process	87.5	27	92.6	29
Planning and working out solutions	88.9	10	88.9	10
All categories combined	94.4	692	94.1	711

* Judge A_1 is the investigator; judge B is the independent judge. A_2 represents the rescoring by the investigator.

† *N* stands for the number of items on which the percentage of agreement was based.

both sets of classifications and the percentage of agreement between them are summarized, category by category, in Table 3.

H. Measurement of Change in the Subjects

As was indicated above, the criterion used to evaluate extent of change in the various members of the experimental group was the Thematic Apperception Test (TAT), administered before and after therapy.

The test protocols were submitted to an independent interpreter for blind analysis. This means that the interpreter was given only: (*a*) the subject's verbatim responses during the test administration, (*b*) time notations for initial reactions, pauses during response, and total time for each picture, and (*c*) his selection of pictures of most and least appeal, with the reasons for his selections, as provided by the client and recorded electrically. The test analyst was also informed of the age, marital status, and family constellation of each subject. He was given no information apart from this except that each individual in the research group was a male veteran of World War II. To further insure objectivity on the part of the test analyst in rendering his judgments, the records were so arranged that he had no way of knowing with certainty which were the pretherapy and which were the posttherapy responses.

Scoring of the tests. It was decided that perhaps the most effective method for evaluating extent of change was through the use of a simple rating scale to which the TAT interpreter would apply his total clinical impressions of the change he detected between each pair of protocols. A ten-point scale was therefore devised, as shown in Fig. 1, with "none" at one extreme, "much" at the other extreme, "little" and "some" as intermediary gradations. In order to refine the results, the test interpreter was also requested to rank the extent of change of those clients who seemed to cluster

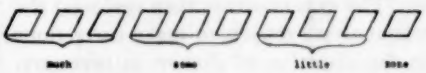

Fig. 1. Scale used for rating extent of change following therapy.

around one or more specific points on the rating scale. The end result was an automatic ranking of all clients from one to nine, there being nine members in the experimental group.

In comparing each subject's pre- and posttherapy sets of responses, the test analyst was asked and agreed to look for the following discrete signs: (*a*) the extent of unification and integration of the personality, (*b*) the degree of neurotic tendency discernible, (*c*) the amount of anxiety present, (*d*) the effectiveness of the tools utilized by the individual in handling stress-creating situations, (*e*) the effectiveness of his intellectual functioning, (*f*) the feelings and attitudes held toward self, (*g*) the feelings and attitudes held toward key people in his environment, and (*h*) the feelings and attitudes held toward the world-at-large and toward all the ordinary tasks of daily living.

Finally, the test interpreter was to: (*a*) designate which, in each pair of protocols, he considered to be the pretherapy and which the posttherapy set of responses, and (*b*) indicate the direction of the change, whether "positive" or "negative." Change in a "positive" direction was considered to be in evidence when the client appeared to have healthier feelings and attitudes toward

himself and the world around him, when his personality seemed better integrated and unified, when there appeared to be a diminished degree of neurotic tendency and anxiety present, a higher level of intellectual functioning, greater capacity to deal with stress-creating situations, etc. The experimenter then reviewed the test analyst's reports to make corrections in the direction of change, as necessary.

Summary of test results. Two of the nine pairs of TAT protocols (for "Davis" and "White") were judged to evidence "much" change; three (for "Robbins," "Walker," and "Peters") showed "some" change; another three (for "Summers," "Black," and "Collins") showed "little" change; and the change manifested by the last remaining member of the group ("Patterson") was deemed to be so slight as to be virtually negligible. This last individual was therefore placed in the "none" or "no change" classification.

The TAT analyst's judgment as to which were the pre- and which were the posttherapy sets of responses was correct in all instances. All the personality differences which he found following therapy he judged to be "positive" in direction. This means that the over-all results presented above represent varying degrees of improved adjustment achieved as a consequence of therapy.

III. TESTING THE HYPOTHESIS—STATISTICAL PROCEDURES

Once reliability of the classification system and the experimenter's judgments had been established, it was decided that the "patterns of feelings" exhibited by each client could best be traced by dividing his total treatment experience into stages. The unit selected for this purpose was the third of the therapeutic process. This means that the total number of postinterview recordings in each case was divided into thirds. (In instances where the total number of postinterview recordings could not be divided into three equal parts, the principle followed was to compose the first and last thirds of an identical number of recordings, while the middle third consisted of either one more or one less recording than did the two other thirds.)

Four procedures were then utilized to analyze the contents of the postinterview recordings and to relate the results to the findings of the TAT analyst. The first two were concerned with the relative frequency with which the client comments lent themselves to classification in the nine categories which had been set up—this aspect of the statistical treatment is herein called "area analysis." The two remaining procedures dealt with the direction and intensity of the feelings and attitudes verbalized by the clients and the referent of their feelings and attitudes—herein called "value analysis." All four procedures were applied to the whole as well as to the three phases of the treatment process.

A. Area Analysis

It will be recalled that the question posed to the clients under study at the end of each treatment session was a loosely structured one. For this reason, it seemed pertinent to determine (*a*) to what extent the use made of the ten-minute postinterview periods was similar or different in the nine cases, and (*b*) if differences did emerge, whether or not these differences could be related in a meaningful way to the judgments of the

TABLE 4

RANK ORDER OF USE OF CLIENT CONTENT CATEGORIES IN THE NINE CASES

Case	Self Current	Self Past	Counselor	Process	Sharing and Confiding	Feeling Tone during Hour	Feeling Tone outside Hour	Outcome	Insight
Davis	2	9	6	4	5	7.5	1	7.5	3
White	1	9	3	5	6	7	2	8	4
Robbins	3	9	5	1	6	8	4	7	2
Walker	2	9	8	7	4	5.5	3	5.5	1
Peters	3	7.5	6	2	7.5	9	4	5	1
Summers	3	9	8	2	6	7	5	4	1
Black	2.5	9	4	5.5	5.5	1	7	8	2.5
Collins	4	9	3	1	5	2	8	6.5	6.5
Patterson	2	9	7	5	4	1	6	8	3
Sum*	22.5	79.5	50	32.5	49	48	40	59.5	24
Sum minus mean*	22.5	34.5	5	12.5	4	3	5	14.5	21

* For total table, Sum = 405; Mean = 45; $W = .530$.

TAT analyst as to outcome of therapy.

Group concordance of approach. The first problem then was to secure a simple, preliminary measure of the extent of commonality of approach among the nine subjects. This was done through use of Kendall's W statistic (8, pp. 81-89). To determine the coefficient of concordance by Kendall's method, it was first necessary to establish the frequencies distributed in each category in each client case. These raw frequencies were then converted to percentages in order to set down in uniform units the proportion of his total number of remarks which each client devoted to each category. The resulting percentages were ranked, client by client, as illustrated in Table 4, and the following formula[8] was applied:

$$W = \frac{12\ S}{m^2(n^3-n)}$$

The rankings contained in Table 4 yielded a coefficient of concordance of .530. This means that the subjects under study differed appreciably among themselves in their over-all approach to the ten-minute periods. The degrees of similarity and difference in approach were found to be approximately the same for the first and last phases of treatment (.489 and .505, respectively), with an increase in variability taking place in the second phase (W for the second phase was .309).[9] Further examination of the data suggested that this was owing to shift in focus on the part of some of the subjects, rather than the entire group.

Concordance within subgroups. The next objective was to investigate whether or not a higher order of congruence of approach was present among the several members of each group who had been assessed to have experienced approximately the same extent of change than had been found when all nine cases were considered simultaneously. Toward this end, the total group of nine was divided into subgroups: (*a*) Group I, consisting of Davis and White, who had undergone "much" change, (*b*) Group II, composed of Robbins, Walker, and Peters, who had been judged to evidence "some" change, and (*c*) Group III, including Summers, Black, and Collins, who had been classified as manifesting "little" change and Patterson, who exhibited "no" change.

The results of this analysis (see Table 5) indicated that each subgroup tended to focus on the same elements in their postinterview discussions to such an ex-

[8] S represents the sum of the squares of the deviations from the mean; m, the number of rows; n, the number of columns.

[9] Each of these W values is significant at beyond the 1 per cent level.

TABLE 5

MEASURES OF CONCORDANCE OBTAINED FOR THE THREE SUBGROUPS AND FOR ALL NINE CLIENTS, FOR THE WHOLE AND BY THIRDS OF THE TREATMENT PROCESS*

Group	Whole	First Third	Second Third	Last Third
I (much change)	.750	.639	.612	.729
II (some change)	.751	.580	.654	.746
III (little or no change)	.607	.635	.451	.741
Total group	.530	.489	.390	.505

* With the exception of the figures which pertain to Group I, all of the coefficients which appear above were derived through use of Kendall's *W* statistic. Kendall's tau was used to measure extent of agreement between the members of Group I since *W* is not applicable where the population is less than three. The use of tau is explained in the text.

tent that the degree of concordance within subgroups was *appreciably greater* than when the entire group of nine clients was treated as a whole.

Specific areas of concentration. The final question in the "area analysis" was concerned with whether or not meaningful relationships could be uncovered between the *relative* frequencies (rank order of use of each category) with which the client's remarks were distributed in the various categories and the position to which he had been assigned on the "much" to "no" change scale by the TAT analyst. In other words, could a significant relationship be observed between the areas on which these clients elected to concentrate and the extent of change which they experienced as a consequence of therapy?

To answer this question, coefficients of correlation were obtained for each category through use of Kendall's tau (8, pp. 1-24).[10,11]

$$\text{tau} = \frac{S}{\frac{1}{2}\,n\,(n-1)}$$

Where tied ranks were present, this formula was adjusted in accordance with Kendall's recommendations (8, pp. 25-36).

The significance of each derived correlation coefficient was also tested to ascertain the extent of the probability that the figure obtained or a greater figure could have arisen by chance. In all instances, the significance level cited is in terms of absolute values. The values of tau are shown in Table 6.

B. VALUE ANALYSIS (DIRECTION AND INTENSITY)

The two remaining procedures are concerned with the central hypothesis to be tested in this experiment. They deal with the feelings and attitudes expressed by the subjects under study and the referents of their feelings and attitudes. In brief, the following are the key problems to be explored by the "value analysis": (*a*) Were these clients homogeneous with respect to the nature of the feelings and attitudes they verbalized in their postinterview recordings as they went through treatment, and (*b*) can the findings which emerge be meaningfully related to the judgments of the TAT analyst?

In order to answer these questions, the data were treated statistically in two ways: (*a*) The frequencies of positive

[10] Kendall's tau is identical to Spearman's rho in that both coefficients are symmetrical about the value zero. Both range from −1 to +1. However, the two coefficients are based on different scales, resulting in rho often being 50 per cent greater than tau when neither coefficient is close to either −1 or +1.

[11] *S* represents the sum of the positive and negative scores, *n* the number of units in the set of ranks. The numerator therefore is the actual or total score, while the denominator is the maximum possible score.

TABLE 6

RANK CORRELATION BETWEEN OUTCOME OF THERAPY AND THE RELATIVE FREQUENCY WITH WHICH THE CLIENT COMMENTS WERE CLASSIFIED IN THE CATEGORIES*

Category	Correlation Coefficient			
	Whole	First Third	Second Third	Last Third
Current perception of self	.22	.22	.72 (.01)	.16
Feelings and attitudes re counselor	−.22	−.27	−.42	−.05
Feelings and attitudes re process	−.27	−.27	−.22	−.22
Feelings and attitudes re sharing and confiding	−.55 (.05)	−.38	−.53 (.06)	−.33
Anticipation of outcome	−.16	−.16	−.26	−.11
Feeling tone during hour	−.72 (.01)	−.55 (.05)	−.53 (.06)	−.76 (.01)
Feeling tone outside hour	.72 (.01)	.66 (.02)	.66 (.02)	.66 (.02)
Insight				
Insight and self-understanding	−.11	0	.11	.50 (.08)
Insight into the nature of process	0	−.11	.22	.19
Planning and working out solutions	.11	†	†	.47
Affect associated with current self-perception	.61 (.03)	.40	.53 (.06)	.64 (.02)

* The number which appears in parentheses after some of the tau values represents the level of significance. Significance levels of 10 per cent or lower only have been included here. In all instances, the significance level presented is in terms of absolute values.

† No tau value was obtained in this instance since less than seven members of the group could be ranked and since the experimenter had arbitrarily decided to secure a tau value only when the set to be worked with contained a minimum of seven rankings.

comments were expressed as a proportion of the total number of comments classified in each category in each client case, and (*b*) an attempt was made to determine the average affective score for each category in each client case. Both procedures were applied to the whole as well as to the three phases of the treatment process. The rationale for the use of each is presented below.

Ratio of positive to total number of remarks classified. The third technique, though simple, was adopted for use here on the basis that it had proved to be of value to other workers (18, 22, 25, 27). First, the ratio of positive to total number of remarks in each client case for the whole of the treatment process was calculated. Inspection of the ratios revealed that the relative frequency of positive remarks classified in each category was not equal among the nine subjects, that variability among them in this respect was marked. Thus the spread of ratios was from 100 to 24.7 in the category "feelings and attitudes in relation to counselor," from 100 to 7.1 in the category "feelings and attitudes in relation to process," and from 90.0 to 10.9 in the category "feeling tone during hour."

In order to relate these findings to the judgments of the TAT analyst, the ratios were ranked, by comparison of each subject with every other member of the group. Correlation coefficients were then obtained, category by category, using Kendall's tau. The same process was followed in analyzing the feelings and attitudes expressed by the clients during the three stages of their treatment experience. The over-all results are summarized in Table 7.

The client's average affective response. The fourth procedure used was designed to correct what was considered to be a deficiency in the one described directly above (tau based on proportion of positive to total number of comments

TABLE 7

RANK CORRELATION BETWEEN OUTCOME OF THERAPY AND THE RATIOS OF POSITIVE TO TOTAL NUMBER OF REMARKS CLASSIFIED IN THE CATEGORIES*

Category	Correlation Coefficient			
	Whole	First Third	Second Third	Last Third
Current perception of self	.33	0	.22	.50 (.08)
Feelings and attitudes re counselor	.61 (.04)	.36	.59	.45
Feelings and attitudes re process	.54 (.08)	.45	.38	.48
Feelings and attitudes re sharing and confiding	.76 (.01)	.59 (.08)	.58 (.05)	.61 (.05)
Anticipation of outcome	.76 (.01)	.69 (.02)	†	.57 (.10)
Feeling tone during hour	.66 (.02)	.65 (.02)	.59 (.10)	.33
Feeling tone outside hour	0	0	.18	−.42

* The number which appears in parentheses after some of the tau values represents the level of significance. Significance levels of 10 per cent or lower only have been included here. In all instances, the significance level presented is in terms of absolute values.

† No tau value was obtained in this case since less than seven members of the group could be ranked and since the experimenter had arbitrarily decided to secure a tau value only when the set to be worked with contained a minimum of seven rankings.

classified). It differs from this third procedure in that it did not separate out the positive remarks only. Instead, each client expression was assigned a weighted value according to the direction and intensity of the feeling or attitude involved, thereby making possible more discriminating differentiation between the client who was totally negative in his reactions, the client who was less strongly negative, the ambivalent client, etc.[12]

A seven-point scale was set up with each numerical value on the scale having equivalence to a specific direction and specific intensity, as follows: 7 = increasingly positive; 6 = positive; 5 = diminishingly positive; 4 = ambivalence; 3 = diminishingly negative; 2 = negative; and 1 = increasingly negative.

The client's total affective score in each category was computed by multiplying the number of expressions classified by their appropriate numerical equivalents. This figure was then divided by the number of frequencies classified to yield his *average* affective score or response. The resulting average affective scores were ranked, category by category, and correlations between these sets of ranks and the TAT rankings were again secured through use of Kendall's tau.

It developed that the findings yielded by the fourth procedure were essentially the same as those yielded by the third. While there were some minor variations in the two sets of correlation coefficients, in no instance did expressing the client's positive remarks as a proportion of his total number of remarks fail to pick up the trend which emerged when weighted values were assigned to all his remarks. Thus, the third procedure did make available a fairly accurate picture of the comparative perceptions and reactions of the clients under study while, at the same time, it was a considerably easier statistical tool with which to work, and did not require a series of inferences as to the emotion attending comments classified under the supplementary subheadings of the categories used to

[12] A similar procedure was previously successfully employed by Stock (26).

analyse the data.[13] The advantage which the fourth procedure retained over the third is that, in the process of assigning numerical values to all the various expressions classified, additional qualitative findings emerged which might otherwise have been obscured (12).

IV. RESULTS OF THE ANALYSIS OF THE POSTINTERVIEW RECORDINGS

To facilitate review of the statistical findings, the correlations for each category are summarized in Table 8, which is a composite of Tables 6 and 7. Since the meaning of these correlations is self-evident, the section to follow has been limited to presentation of additional pertinent quantitative material brought to light by further examination of the raw data and obscured by the correlations.

Current Perception of Self

1. The raw data show that, while the four clients judged to have exhibited most change reported more positive self-perceptions in the second phase of therapy than they had in the first, there was a reversal of this trend by three of the five remaining clients. Nevertheless, eight of the nine individuals under study reported perceiving themselves more favorably by the time therapy was terminated than when it was initiated.

2. It was also found that, while the two clients judged to have evidenced "much" change continued to have as much affect associated with all their self-referential comments in the second third of therapy as they had in the first, and, while the self-referential comments of the three clients who manifested "some" change were attended by affect more often in the second third than in the first, there was increased *dissociation* of affect from self-perception in the second third by the three members of the "little" change group and the one client who manifested "no" change. The two individuals who manifested more dissociation of affect from perception of self in the last phase of therapy than they did in the first were members of the "little" change group.

Feelings and Attitudes in Relation to Counselor

The one client who exhibited "no" change and two of the three who exhibited "little" change were relatively less favorably disposed toward the counselor in the second phase of treatment than they had been in the first. Three of the four individuals who continued to report some negative feelings and attitudes with respect to the counselor in the last phase of therapy were members of the "little" change group. Only one subject verbalized more negative feelings and attitudes toward the counselor in the last phase than he did in the first. This individual was in the "little" change group.

Feelings and Attitudes in Relation to Process

While five of the nine clients under study retained some negative feelings about "process" in the last phase of therapy, all five reported fewer negative and more positive feelings about "process" in the last phase than they had in either the first or second phases. Four of these five individuals were the four judged to show least change.

Feelings and Attitudes in Relation to Sharing and Confiding

All of the clients under study (except the two who manifested most change) expressed relatively fewer positive feelings about sharing and confiding in the second third of their treatment experience than they did in either the first or last thirds. Further, while the two clients who showed "much" change remained favorably disposed to sharing and confiding throughout the course of their treatment and while the three who showed "some" change were highly successful in master-

[13] While this seven-point scale refers only to positive, negative, and ambivalent expressions, it will be recalled that the categorization system developed permitted classification of additional types of client comments (e.g., "fantasy" about the counselor, "blocking" in the area of sharing and confiding). Numerical values on the seven-point scale were assigned to these supplementary types of client expressions also and the rationale for the decision reached in each instance is presented in the body of the dissertation proper. To illustrate: "blocking" items were scored as negative comments for purposes of this analysis on the grounds that both types of expressions indicate the presence of a barrier within the client to communicating with the counselor, thereby resulting in withholding. "Blocking" items without valence were therefore given a numerical value of 2 each; comments in which the client reported increased "blocking" were assigned a value of 1 each, etc.

TABLE 8

COMPOSITE TABLE SHOWING RESULTS OF AREA AND VALUE ANALYSIS*

Category	Correlation Coefficients							
	Whole	p**	First Third	p**	Second Third	p**	Last Third	p**
Current perception of self								
Area analysis	.22		.22		.72	.01	.16	
Value analysis	.33		0		.22		.50	.08
Affect re self	.61	.03	.40		.53	.06	.64	.02
Feelings re counselor								
Area analysis	−.22		−.27		−.42		−.05	
Value analysis	.61	.04	.36		.59		.45	
Feelings re process								
Area analysis	−.27		−.27		−.22		−.22	
Value analysis	.54	.08	.45		.38		.48	
Sharing and confiding								
Area analysis	−.55	.05	−.38		−.53	.06	−.33	
Value analysis	.76	.01	.59	.08	.58	.05	.61	.05
Anticipation of outcome								
Area analysis	−.16		−.16		−.26		−.11	
Value analysis	.76	.01	.69	.02	†		.57	.10
Feeling tone during hour								
Area analysis	−.72	.01	−.55	.05	−.53	.06	−.76	.01
Value analysis	.66	.02	.65	.02	.59	.10	.33	
Feeling tone outside hour								
Area analysis	.72	.01	.66	.02	.66	.02	.66	.02
Value analysis	0		0		.18		−.42	
Insight								
Self-understanding	−.11		0		.11		.50	.08
Into process	0		−.11		.22		.19	
Planning—solutions	.11		†		†		.47	

* "Area analysis" presents the tau values based on the relative frequency with which the client comments were classified in the categories; "value analysis" presents the tau values based on the ratios of positive to total number of comments classified in the categories.

** Significance levels of 10 per cent or lower only are included here. All significance levels cited are in terms of absolute values.

† No tau value was obtained in this instance since less than seven members of the group could be ranked and since the experimenter had arbitrarily decided to secure a tau value only if the set to be worked with contained a minimum of seven rankings.

ing their reservations about sharing and confiding prior to closure of therapy, the four group members who exhibited least change continued to express considerable resistance to opening up even in the last phase of treatment. Two of these four expressed even less positive feelings about sharing and confiding in the last phase than they had in the first.

Anticipation of Outcome

All of the subjects who came to therapy with reservations about outcome reported fewer negative and more positive feelings about outcome in the last phase of their treatment experience than they did in the first.

Feeling Tone during Hour

Most of the clients under study experienced increased "during the hour" comfort as therapy entered the last phase. The one individual who reported increasing discomfort as therapy proceeded was a member of the "little" change group.

Feeling Tone outside Hour

While it is not presumed here that verbalized feelings of comfort are synonymous with improved, healthy adjustment or that effective therapy necessarily yields immediate and complete relief from physical and/or psychological discomfort, the inverse relationship which

emerged in the last third (—.42) between therapeutic success and reported feelings of comfort seemed sufficiently interesting to warrant intensive study of the data.

Review of the data revealed gross variability among the nine clients with respect to the relative frequency with which they reported on their "outside hour" feeling tone during the last third. For example, while Davis (Client No. 1) made 53 references to his "outside the hour" feeling tone in the four recordings which constituted the last third of his treatment experience, Patterson (Client No. 9) made only six comments in the seven recordings which comprised the last third of his treatment experience. Further, all six comments made by Patterson appeared in his fifteenth document, leaving six subsequent recordings in which he made no comment at all as to how he felt between sessions. Similarly, in two recordings, White (Client No. 2) made 21 references to his "outside the hour" feeling tone, while in six recordings, Collins (Client No. 8) made only 11 comments.

In view of the fact that Patterson made no mention at all of his "outside the hour" feeling tone in the last six of the 21 postinterview recordings which he made as part of this experiment, it seemed justifiable to omit him from the calculation of the correlation for the last third. While this procedure did alter the resulting value somewhat (it now became —.26), there still proved to be an inverse relationship between successful outcome of therapy and the relative number of "outside the hour" feelings of comfort reported by these clients.

The other and more interesting finding uncovered was that Collins (Client No. 8) was the sole member of the group whose reported "outside the hour" feeling tone shifted radically from negative to positive. That is, while all the other group members talked of diminishing personal discomfort before reporting feelings of comfort, Collins' "outside the hour" feeling tone did not seem to go through intermediary stages. The totality of the change in his feeling tone is therefore clinically suspect. That Collins himself was aware of this is implicit in his own statements.

Collins told the focused interviewer that he began to notice change "about three or four weeks ago."

"It was most peculiar . . . one of the most surprising, most amazing things that would ever happen to a man . . . I believe . . . in the way I was feeling . . . to ah suddenly come about and feel this way . . . more free and easy, more lively, more light. . . and to shake off this whole heaviness that seemed to be surrounding me and gripping. Now how that could suddenly break off at that one particular point I don't know, but it did happen . . . The sudden break is too sharp . . . too sharp. It's too sharp to be ah . . . I don't know if these things are supposed to come slowly or sharply . . . I don't know . . . like an electric shock treatment or something . . . I don't know . . . but . . . there was no shock at all . . . it just happened."[14]

There is additional clinical evidence in our data to suggest that the sudden relief from tension which Collins experienced may be a manifestation of the setting in of a new defense against anxiety. He used his new-found sense of vitality and well-being to support him in his wish for rapid closure of therapy, for he was exceedingly fearful lest his rickety controls topple should he continue with his exploration of himself and his emotionalized attitudes. That he was making a desperate effort to keep his feelings in check is also borne out by his increased dissociation of affect from perception of self in the last phase of therapy and by the behavior and concerns which he exhibited during the administration of the second TAT. He became increasingly disturbed as the test proceeded and eventually he was unable to make up stories about the last three cards. He stated:

"My mind just refused to think about them (the last three cards) . . . There was nothing to be made of those particular pictures because my mind stayed blank right there . . . It just wouldn't move any further . . . without any logic to it . . . something reasonable to it . . . and those last three cards just didn't have any . . .

"I'd rather keep it (my mind) just where it should be as far as things about me go and not sort of look at one thing and not make up a lot of whole unrelated things toward it . . . sort of make it bigger than it is. I mean I look at the thing and tell it according to the way I see it and that's all . . . not fatten up the story a little bit . . . and get it out of all sense of proportion. I don't like to do that . . . and I believe if you go ahead and look at one thing and think too much about it, you're just liable to get it out of all sense of proportion and eventually you'll live in a world like that."

Our data show that the most positive "outside the hour" feeling tones were not reported by the two clients who exhibited most change, suggesting that complete relief from tension or feelings of personal comfort do not always go hand-in-hand with successful therapy.[15] In fact, it is very probable that successful therapy does not yield freedom from distress, at least until such time as the individual has had sufficient opportunity to integrate his new way of perceiving, reacting, and behaving.

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[14] Excerpted from focused interview material.

[15] A recent study by Meadow, Greenblatt, *et al.* (13), which postdates completion of the writer's dissertation, seems to support this point of view.

V. THE CLIENT DESCRIBES HIS TREATMENT EXPERIENCE

This section presents an overview of the therapeutic process as it progressed for two members of the group under study.[16] These two cases were selected for this purpose since they depict some of the interesting and differing patterns uncovered in the statistical analysis of the postinterview recordings.

Each client is discussed separately and excerpts from his postinterview documents and his focused interview material are quoted verbatim. An attempt has been made to present the circumstances surrounding his coming to treatment, his version of his problem at the outset of therapy, his reaction to referral for service, and how he viewed his situation at the end of therapy.

It seems pertinent to recall at this time that the final focused interviews were all conducted by a second clinician, who was provided with a guide outlining specific areas for inquiry, but used nondirective interviewing techniques. Since the questions posed to each client were, for the most part, unstructured and since the interviewer followed the client's lead, the interviews invariably contained some client digressions which were of no significance in terms of this research. The case discussions have therefore been restricted to present relevant material only, that is, material which provides an understanding of the specific, idiosyncratic meaning of the treatment experience to the client. The case material follows.

Client No. 1: Mr. Davis (Age 23) 11 Sessions—"Much" Change

Davis came to the guidance center for permission to receive training in a field other than that in which he was currently employed. In the course of testing, it was discovered that he had what he called a "nervous condition" and he was referred to the writer for counseling. Davis was "glad and thankful" (*first postinterview recording*) to learn that this service was available to him, as he was suffering severe physical and mental distress. Earlier, he had sought help for this condition at another veterans installation, where he had been placed on a waiting list. He summarized his presenting problems at the outset of therapy as follows:

"First of all, it started with headaches and dizziness . . . and it started very mild. And then, they continued to get worse and the periods between these times started to get more often and more often . . . you know, closer together until it started happening every day. And then quite a few times every day until I just felt weak and just so I couldn't move at all, see. And I was getting funny feelings all through, you know . . . my stomach and system below there" (*focused interview material*).

Davis' difficulties were diagnosed as "nerves" at the first veterans center which he visited. He later told the focus interviewer that he did not "understand or really realize how anything like that could be," that he "didn't know anything about nervous reactions" at the time, especially since he had no way of distinguishing between symptoms based on purely physical dysfunction and those of psychic origin. He had little idea of what to expect in counseling, but he did anticipate that it was to be a shared experience. He also had a certain amount of conviction that his problem could be successfully resolved:

"Like I say, I didn't know what it was all about. And that was the whole feeling at the beginning. I didn't know what to expect or think . . . and then again, I had the feeling that I could be helped, too. That was one of the things that I seemed for certain to take for granted . . . and maybe to hear something that they know different. And then I thought that there was something that I could get out of it by doing my part, I guess" (*focused interview material*).

One responsibility which Davis saw as his was to share with and confide in the counselor as completely as possible. He stated that "I knew I had to be frank and tell everything that's . . . I mean truthful as it may be, just . . . even if the truth hurts yourself, it's the only way to find out" (*focused interview material*).

He therefore entered therapy with this in mind and he reported in his first postinterview recording that he was already beginning to find that "a few things that (he) never did realize could bring up these conflicts and ways were beginning

[16] Similar overviews for the remaining members of the experimental group appear in the body of the dissertation.

to show up now because this . . . of this freedom to not be afraid to . . . to bring out things that would be harmful to (him)."

Davis told the focus interviewer that he had given no thought to the counselor prior to contact with him. He had been concerned primarily with "the process" and he had assumed that the counselor had the necessary training and skills to help in the resolution of his difficulties. He had half expected the counselor to tell him what was wrong, but he expected "mainly to find out for himself" (*focused interview excerpt*). He had an immediate positive reaction to the counselor whom he described in his first postinterview recording as a "very congenial gentleman and someone you can trust and have confidence in," with a "personality of . . . of ah consideration and helpfulness." He remained positive in his orientation and response to the counselor throughout the course of treatment, as he did to sharing with and confiding in him. He recognized early that the counselor was nonjudgmental and felt free to discuss those aspects of his personality which he considered to be negative rather "than trying to think that I'm letting somebody in on something they shouldn't know or telling about . . . being afraid to tell him about things that I shouldn't have done or should have done or have enjoyed or not enjoyed or what I do like and what I don't like" (*third postinterview recording*).

Davis began reaching fuller self-understanding from the very beginning of his treatment experience. Directly following his first session, he reported that counseling was "enlightening (his) thinking on a lot of things," that his problems were "beginning to fit in like a glove, one thing into another." He also found that self-exploration led to a lifting of the "fogginess" which had characterized his thinking for several months and this caused him to become increasingly self-confident. The insights he achieved and the new confidence he gained were apparently immediately reflected in his daily functioning, for in his second postinterview recording he reported diminished personal discomfort "outside the hour." Nevertheless, he still complained of being in a "crabby mood" most of the time, of tension and sleeplessness.

As therapy proceeded, Davis became aware of conflicting forces within his personality that were struggling against each other and "upsetting" him. He referred to these conflicting forces as "fightings" within himself. He saw the role that his mother's suspicious nature had played in causing him to be on guard in his relationships with others and how her subtle depreciation of him had made it difficult for him to trust his own judgment. Not having sufficient confidence in himself, he had permitted his thinking to be "dominated" by others to the point where it seemed that "everybody was getting what they want . . . nothing for yourself" (*third postinterview recording*).

Initially, it was not easy for Davis to accept and integrate his new insights. He told the focus interviewer: "The truth hurted because to me it didn't seem it was possible," but then, ". . . when I noticed the way it reacted on me" and that "these fightings were the only thing that was reacting on me . . . then, after that, I started to feel much better."

As Davis acquired increased understanding of the nature and source of his difficulties, his new knowledge served to buttress his confidence in himself and his own values. He reported that he was now able to fight back when others were critical of him or tried to sway him from his course, and he spoke of having "more pep" and "more initiative" to do the things he wished "instead of having a fear to do them" (*fourth postinterview recording*). He also mentioned that his symptoms were slowly beginning to go, "little by little, one by one," and that "it makes you sort of probably feel more mad about the one simple . . . or the one or two simple things that are left, when all the big job that has to be done is gone" (*fourth postinterview recording*).

Davis derived much gratification from self-direction and he was able to see value in assuming responsibility for himself and in working out his own solutions in the treatment relationship. "As it was going on, I found out more or less what it was really about and I have more confidence in it, rather than just being an outline or something that you're told is the way to be" (*focused interview material*).

He summarized his impression of his experience in counseling as:

"More or less a . . . a study of problems or something that will upset your system . . . what you're like and what you do and so forth. I found it was getting to have an understanding of yourself more than just taking a lot of things for granted. And, like I say, in my case, that's what I actually found out. With me, it was more of an understanding of myself and things and the way they were going on. And that's just about what it amounted to as we were going along" (*focused interview material*).

Before treatment was concluded, Davis learned to assert himself. He married his fiancee, despite the wishes of her mother and his, thus freeing himself from maternal domination. He seemed considerably more comfortable in his daily functioning, and he spontaneously decided to terminate therapy when he believed he had nothing new to discuss.

"When I found out it was the same thing I was thinking about, that's when I wanted to stop. See, I found that these problems were just short

a matter of time to get away from what was left because I felt that I sort of understood what was going on. And I found that it wasn't something new or something else . . . it was getting to be the same thing that was occupying my mind and all and it seemed to be a slow process of getting away from it. . . . And I felt that it would be more or less a little bit of time by myself and other circumstances that have to take a little time and that I would straighten them out myself. . . . And that's the way I figured it" *(focused interview material).*

Davis was pleased with the changes he saw in himself and he related these changes to his experience in treatment.

"If it's something that you know, then there's something you can do about it. I can do something about it now. I don't have to be in the dark any more and it feels better to feel good again . . . to be able to do things again. And I like it better this way and I'm glad it's turning out that way" *(focused interview material).*

From the excerpts quoted above, it may be seen that Davis terminated treatment before all his symptoms had disappeared. He felt confident that the process set in motion by therapy was an effective one, that it was only a matter of time before he would experience complete relief from distress. He was satisfied with the progress he had achieved and he reported that he had worked out some of his difficulties in the ten-minute periods allotted to him at the end of each interview, as well as during the interviews themselves.

"Well, it was a good thing to . . . to me, it seemed . . . to try and figure out the way I really felt . . . a chance to really let out the way I was and what the problems were and so forth. It was mostly by myself to really say just what I want the way I want and just about all that was bothering me, too. You see, you had it all by yourself. It was not as if you were talking to yourself, but you could give yourself confidence that way and feel that something good would come of it . . . when you thought about it there by yourself" *(focused interview material).*

Thus, Davis used the ten-minute periods virtually as an extension of the counseling sessions. He devoted a considerable proportion of them to further exploration of his problems, to clarification of his feelings and attitudes, and for consolidation of the insights he had achieved. He spoke relatively infrequently of the feelings he experienced as he talked with the counselor, and he seemed primarily concerned with his day-to-day living and functioning. Those remarks which he did make relative to counselor and "process" were positive ones, indicating a favorable orientation to therapy and a real willingness to move out into relationship with the counselor. He manifested no reluctance to sharing and confiding, and he seemed confident from the first that treatment would help him in the resolution of his difficulties. His motivation for therapy was strong and, by the time therapy was concluded, he had acquired a considerable measure of self-understanding which permitted him to free himself of some of the conflicting forces in his personality and the severe physical symptoms to which they had given rise. As a consequence of his experience in treatment, he was better able to utilize his inherent capacities for self-direction, to interact with others as an equal instead of being acted upon by others.

Client No. 9: Mr. Patterson (Age 22) 21 Sessions—"No" Change

Patterson did not begin treatment until six months after referral for service by his vocational adviser. It seems that he "forgot" his first appointment until he chanced upon the appointment slip in his wallet about one month after the date for which his first meeting had been scheduled. He later told the focus interviewer that he had "read Freud" and that he had concluded that: "Evidently I wanted to forget that and I questioned myself why I wanted to forget it and then I came across those reasons of what I expected and so forth . . . Well, like I told you I expected the counselor to be like."

Patterson reported that he had put off requesting another appointment because he had anticipated that the counseling process would be "long delayed and probably nothing would happen" *(focused interview material).* He also had had "fantastic visions" of the counselor which caused him to be reluctant to enter into relationship with him. He had expected that "he (the counselor) was probably like a psychiatrist, maybe foreign, rather impatient . . . ah . . . criticize . . . criticizing things that I did" *(excerpted from focused interview material).*

Though he expected criticism and "was a little afraid of criticism," Patterson eventually came to treatment when he recognized that his problems were too complicated for him to resolve without external help. He was uncertain as to whether or not he wished to continue in his marriage, and he was concerned with the fact that he was "withdrawing into (himself)" and that he was "not standing up for his rights." Nevertheless, he was fearful of change within himself, although he "didn't exactly like the way (he) was" *(excerpted from focused interview material).* He explained his reluctance to change in the following terms during the course of his final focused interview:

"I was a little afraid of changing. I felt maybe it would be too big. I felt maybe it would be a big change and I wouldn't be able to handle it.

"And I was a little frightened of changing because I'd more or less gotten used to the idea of taking everything and keeping it within myself.

I . . . ah . . . never lost my temper or anything. I just kept everything within myself and it was . . . well, that grew up with me, I think, that fear, that inward feeling. And ah I just . . . I didn't think . . . well, at first, I didn't think that I could get those feelings out. And then, a lot of times, I rely on those feelings . . . They're something, like memories . . . not good or bad memories . . . but ah, a lot of times, they're something to think about. And I figured if I got rid of those feelings or those . . . well, those feelings that I had about certain things, ah, what would I do? What would I go back on? . . . think about?"

Thus, while he did not approve of the withdrawal tendencies which he perceived in himself or of his inability to assert his "rights," the secondary gains which these characteristics provided caused Patterson to be ambivalent about relinquishing them. In his first postinterview recording he also reported, "I don't really know whether I'm happy the way I am or unhappy," that he was fearful of becoming "more human in feelings." He described himself as feeling "cold about everything," as not wishing basic change in himself, but rather that counseling would help him become "a little more human, in the conventional sense."

Patterson therefore entered treatment with limited goals and with many reservations. His many conflicting feelings caused him to be guarded in his relationship with the therapist and resistive to sharing and confiding. In his third postinterview recording he commented, "I've kept myself ah under emotionally so long that it would be hard to bring any of that out. . . . And, until I feel that someone will understand how I feel, I probably will always keep it under." Later he told the focus interviewer that at first he was "more or less sizing up what the situation was here," that he was continually watching for counselor reaction, and that "I was trying to find out as much about him (the counselor) as I was telling him about myself."

Though he recognized early in his treatment experience that "He (the counselor) can't help me unless I tell him everything that I know and that I think" *(excerpted from focused interview material)*, and, though he verbalized increasing faith and confidence in the counselor, Patterson continued to hold back to some extent throughout the course of treatment. At times his withholding was deliberate; at other times there was what he himself called "unintentional blocking." He described his fourth interview as a "contest" in which he was "fighting" the counselor; he talked of being "more reluctant to give out (his) thoughts" and of his impression that "the counselor is beginning to see through some of the ah things that I build up around myself to keep him from seeing." He also reported awareness of a "block" in his thinking so that "(his) mind just refuses to stay on that thought" *(fourth postinterview recording)*.

In his fifth postinterview recording, Patterson spoke of his attempts to lead the counselor into "blind alleys" and of being "touchy on a few of the subjects." He considered it a sign of progress that his feeling were coming "closer to the surface" and he seemed pleased when he perceived that he was loosening up a little. Nevertheless, he continued to "block" as therapy proceeded, as is apparent in the several verbatim quotations which follow.

Sixth postinterview recording: "I feel that the things that I should get out won't come out at present. That irritates me a great deal. . . . I'm also aware that the things that I talk about . . . go around in circles . . . Ah I more or less refuse to bring in some of the other things that perhaps I shouldn't say and so forth."

Seventh postinterview recording: "At times, I catch myself wanting to ah lead the counselor off the track . . . by ah . . . saying things that aren't true. I . . . I have to keep beating myself back on the thing sometimes . . . force myself to think of what I'm talking about."

Eighth postinterview recording: "I noticed today that I did a lot more bargaining than I think I've ever done . . . just more nervous, squirmy, and ah even untrustful of the counselor at times. There were things that came to my mind that . . . I wouldn't ah . . . wouldn't say."

Ninth postinterview recording: "I didn't seem to run into as many blocks today as I usually do. I ran into several . . . and they were fairly obvious. They usually aren't quite as obvious as they were today . . . and ah . . . although there's more of them."

Eleventh postinterview recording: "I felt ah as though the counselor and I were sort of having a contest today . . . ah . . . as though I would say something and mean something else . . . ah . . . and he understood what I meant . . . I'm not sure whether I wanted him to or not."

Thirteenth postinterview recording: "I also feel that I'm throwing up more blocks while I'm here . . . and that I can't understand why. . . . I also felt that I was too mixed up and too unsure and . . . too far away for the counselor to understand what I was saying . . . or, as far as that goes, understand it myself. It seemed as though I was talking . . . in riddles and . . . they led to actually nothing . . . that they needed a lot more thought . . . behind them to ah . . . make them understandable. I feel that I must be going through a big stage of fighting with myself and ah also with the counselor . . . that I refuse to let myself think clearly and ah enough for . . . enough to understand or for the counselor to understand."

Since Patterson told the focus interviewer

that his actual experience in counseling was at gross variance with his earlier expectations, that he began to "build up confidence" in the counselor when he found that the counselor did not respond with shock, anger, amusement, criticism, etc., it would seem that his persistent reluctance to share and confide cannot be attributed to fear of counselor action or reaction. Rather, it is related to his need to maintain his prevailing self-concept and self-structure and to ward off need for change within himself. He told the focus interviewer that he was "a little frightened . . . not only of someone else hearing my troubles, but of myself hearing my own troubles," just as he implied in foregoing quotations that his "blocking" was as much designed to keep *him* from reaching more comprehensive self-understanding as to prevent the counselor from understanding him. He also stated rather emphatically at the outset of treatment: "Yet I won't change my view no matter how I should think about it" *(first postinterview recording)* and "I guess what I hate more than anything else . . . always have hated . . . was a big change . . . within myself . . . not so much a change in surroundings as what is going on within myself . . . I feel that I've had more than my share of changes, emotionally and mentally" *(third postinterview recording)*.

Patterson perceived rather quickly that therapy threatened to disrupt the current balance of forces within his personality. At the end of his third meeting, he commented that he was becoming "more frustrated and nervous," that "things were beginning to effect (him) more than they used to." He spoke of having "a very unreal feeling" about himself, of becoming "distrustful" of himself, of experiencing "unusual feelings that (he) never had before," of wishing he could "get away." Coping with his new, raw feelings sapped so much of his energy as to lead him to say, "I feel, after I've been here, that I've lived an entire day . . . or even more," that he "could easily go to sleep after talking" *(third postinterview recording)*.

As therapy moved into the second phase, Patterson became increasingly uncomfortable during his treatment interviews. His new learning about himself was not always flattering, causing him to feel "more uneasy" and to engage in considerably more "blocking" for fear of "betraying something," which he presumed to be himself *(seventh and eighth postinterview recordings)*.

It would seem that Patterson remained in treatment out of an intellectual need to track down the root of his difficulties and, as he later told the focus interviewer, because he had no one other than the therapist who would take the time to talk with him. His resistiveness to change persisted throughout the course of his experience in treatment, preventing the fulfillment of his overt wish to understand himself and to achieve a more "human" level of adjustment. Though he talked of being irritated, agitated, and impatient with himself because of his inability to open up as fully as he considered desirable, he was never able to break through the "blocks" which he spontaneously recognized as devices to prevent full, objective self-knowledge. Thus, he remained fearful of exposing himself to himself long after he relinquished his concerns about exposing himself to the counselor.

As a consequence of his experience in treatment, Patterson did effect several minor behavioral changes. He began to reach out tentatively for relationships outside his home and he began to assert himself to a small degree within his home. However, he still kept his "mouth shut" about the "big things" and he still had considerable difficulty in mixing with people *(excerpted from focused interview material)*. He also predicted that he could easily revert to his pretherapy level of functioning, that events of less than catastrophic significance could cause this. He gave evidence of awareness that no basic change has been effected in his personality structure in the following remarks taken from his focused interview material:

"A lot of things . . . it could change my whole attitude, draw myself into myself, like I was before. And that's what I'm hoping or trying to keep from happening . . . if anything would happen like that. Because I don't feel I could ever get over those emotions or whatever they are that I have. Not that I'm too old, but they're the big things and it's just almost impossible to get rid of them."

Patterson planned a vacation with his wife during which he hoped to determine whether or not he should remain with her. He was uncertain as to the eventual outcome, but the possibility of separation or divorce from her was no longer as anxiety-provoking as it had been. It was at this point that he terminated therapy, though he told the focus interviewer that he was somewhat ambivalent about discontinuing his relationship with the counselor.

The foregoing discussion shows that Patterson came to counseling with many reservations. His preconceived impressions of the counselor and his own resistiveness to change were such that they prevented his keeping the appointment originally scheduled for him and they caused him to postpone coming to treatment for six months.

Fairly soon after entering treatment, Patterson became more positive in his perception of the counselor and the counseling process. He still wavered from time to time in his predictions as to the outcome of his experience in counseling on the grounds that problems as complex and as

deep-rooted as his do not lend themselves to easy resolution. Throughout the course of treatment, he remained inhibited in his relationship with the counselor. His reluctance to share with and confide in the counselor was deliberate at times, but more often it was involuntary.

Patterson devoted the largest proportion of his postinterview comments to discussing his feeling tone "during the hour." This is understandable in light of the fact that giving even limited expression to his feelings and attitudes in the counseling relationship constituted a new experience, one which elicited reactions within him which were different from those he normally experienced in his daily relationships with others. His postinterview documents also show a consistent concern with his inability to share and confide. This concern is meaningful for it was precisely his tendency to withdraw into himself, his inability to communicate with others, which led him to treatment.

Patterson's statements reveal him to be a highly introspective, fairly insightful individual, cognizant of his inability to move out into relationships with others, aware of the need for a basic reorganization in his structure of self, yet fearful that he would not be able to channel and control the emotions which would be freed as a consequence of self-reorganization. He himself recognized that little change had taken place within him as a result of treatment, that he could easily go back to his pretherapy level of adjustment. Having come to therapy not really wishing basic change in himself, he left, at the end of 21 sessions, pleased with the limited change he perceived in himself.

VI. SUMMARY

It was the purpose of the present experiment to investigate the hypothesis that the patterns of feelings which the client exhibits toward himself, the patterns of attitudes which he holds toward his therapist, and his perception of the therapeutic process bear a relationship to the extent of change which he sustains as a consequence of his experience in therapy. This experiment is grounded in the belief that the subjective frame of reference of the client is a valid and fruitful vantage point for making an objective study of his behavior in the therapeutic interrelationship, and for acquiring deeper insight into the meaning the treatment experience has for him.

A. Description of Design

The experimental group consisted of nine individuals all of whom were treated by means of client-centered therapy. The only bases for selection of cases were the individuals' willingness to participate in this research and a minimum of five treatment sessions.

The criterion used to measure extent of change was the Thematic Apperception Test, administered before and after therapy. The clients were ranked from 1 to 9, "1" representing much change and "9" representing none.

The patterns of feelings which the client exhibited toward himself, the patterns of attitudes which he held toward the therapist, and his perception of the therapeutic process were explored by observing his changing response to the following question:

Describe your feelings about what, if anything, has gone on in this hour, and your feelings about yourself and the counselor during the hour.

The client was routinely asked to discuss this question for a ten-minute period at the end of each counseling session. During this period the counselor was not present, the client's remarks being electrically recorded. These records of the client's remarks are referred to as *postinterview recordings.*

A final focused interview was also held, following each client's decision to conclude therapy and after administration of the posttest. These focused interviews were conducted by someone other than the experimenter; their purpose was to provide an overview of the client's experience in treatment.

To test the hypothesis set forth in

this experiment, nine categories were developed for classification of the contents of the client postinterview recordings. Three of these were demanded by the hypothesis tested; the remaining six, empirically derived, cover an array of elements in which the clients themselves seemed interested and which seemed to have definite pertinence in terms of this research. The contents of the final focused interview were also brought to bear in the tracing of each client's "patterns," and provided information concerning the circumstances surrounding his coming to treatment, his reaction to referral for service, how he viewed his situation at the outset of therapy, and how he saw his situation at the end of therapy.

B. Findings

Our data strongly suggest that the client who is positively oriented to the counselor and the counseling experience and who anticipates that his experience in counseling will be a successful and gratifying one undergoes more change in personality structure than does the client who has reservations about the counseling experience.

The client who perceives the counseling experience favorably is also less prone to discuss his emotional response to the counselor and counseling than is the client who is either ambivalent or negatively disposed to counseling. Thus, the greater the acceptance of the counseling experience, the less pressed the client seemed to be to express his reactions to the therapist, to communicating with the therapist, to evaluate the therapeutic process, etc.

Those clients judged to show greater orders of change consistently discussed themselves and their daily functioning with more emotionality than did those who showed lesser orders of change,[17] but the latter consistently were more preoccupied with their "during the hour" feeling tone, and they described their "during the hour" feeling tone in less positive terms than did the former. Two main explanations suggest themselves for this: (*a*) the emphasis placed in the treatment situation on exploration of their feelings and emotionalized attitudes was probably not as disquieting or threatening to those members of the experimental group whose equilibrium did not rely heavily on repression of affect relative to self; and (*b*) since the clients who manifested greater orders of change were more favorably disposed to treatment, it is probable that they were better able to incorporate any emotional discomfort experienced during their interviews than were the clients who were less positive in their orientation and response to treatment. In brief, it is probable that the former accepted emotional discomfort as part of the whole treatment experience, just as they accepted the therapist, the therapeutic process, and the need to share and confide.

The diverging patterns for the clients showing greater and those showing lesser orders of change seemed to become most crystallized in the midphase of therapy.

a. The four most successful members of the group became more positive in their perception of self, while three of the five remaining clients tended to see themselves less favorably in the second third than they had in the first.

b. Four of the five clients who evidenced greater change entered into fuller discussion of how they perceived themselves in the second stage of therapy than they had in the first, while this was true for only one of the four members of the group of lesser change.

[17] Clients showing greater orders of change are those in the "much" and "some" change groups; those showing lesser orders of change are in the "little" and "no" change groups.

c. The self-referential comments of the more successful group members were attended by affect relatively more often in the second third than they had been in the first, while there was increased *dissociation* of affect from self-perception on the part of the less successful members of the group.

d. There was a considerable increase, from first third to second third, in the negative correlation between outcome of therapy and the percentage of remarks in the categories of (*a*) "feelings and attitudes re counselor," (*b*) "feelings and attitudes re sharing and confiding," and (*c*) "anticipation of outcome."

e. The clients showing greater orders of change continued highly favorably disposed to the counselor or became more favorably disposed to him in the second stage of therapy than they had been in the first; for three of the four clients judged to manifest lesser orders of change this trend was reversed.

The various indices suggest that the clients who exhibited lesser orders of change remained or became increasingly defensive as therapy moved into the second third.[18] A partial explanation for this is to be found in the focused interview material, which shows that the members of the experimental group were not all equally distressed with their functioning when referral for therapy was made.[19] In general, the more successful clients seemed to be more keenly distressed and more eager for change than did the less successful clients, although, from an external frame of reference, the presenting symptomatology of the latter was as severe as that of the former.

The question which logically arises is why the members of the group of lesser change came to treatment at all, since evidently they were deriving some measure of gratification from the tools and techniques they were currently employing in meeting their needs and dealing with the environment. Based on their own subjective reports to the focus interviewer, it would seem that each of these individuals (except one who was totally unaware of existing problems) had already begun to perceive, albeit dimly and vaguely, the falsity of his hypotheses for meeting life. When his own suspicions were subsequently confirmed by external sources (such as his vocational adviser), his logical functions demanded that he accept referral for counseling service. However, inasmuch as these four clients did not *really* wish change, they came to therapy somewhat reluctantly, with many contradictory feelings, and they tended to see in the therapist and the therapeutic interrelationship a threat to the homeostasis which they had achieved. They therefore perceived the field less favorably at the outset of therapy than did those members of the experimental group who wished change more actively.

The negative response of the less successful clients to the stimulus of the field seemed to reach its peak in the second stage of therapy, as the potential threat to their existing self-structure, engendered by the process of self-exploration, increased. It is significant that these clients did not interrupt therapy at this juncture, that they were among the longest cases in the experimental group. Although terminating treatment might offhand seem to offer the simplest solution to the observer, this evidently was not the case from the standpoint of these threatened clients. Instead, it appears that they needed to continue in the treatment relationship, at least until such time as they could once more reach a stable self-structure, one which would again be relatively adequate in meeting their needs and dealing with the environment.

When affirmation of their self-organization is recognized as the goal, the behavior and perceptual attitudes manifested by these clients in the second stage of therapy become meaningful. Their meagre discussion of their current self-perception and their intensified preoccupation with nonself elements stem from their need to avoid further examination of self in order to protect and enhance the existing self. The increase in their negative attitudes toward the counselor and toward communicating with the counselor are also grounded in their need to defend the existing self, to facilitate rallying and regaining of positive self-perception. It is almost as if these clients hoped to build themselves up by tearing down the counselor and the counseling relationship.

In Klein's terms, it might be said that the perceptual attitudes of these clients were acting as "selective valves" to prevent the admission of crucial new self-elements to awareness (9, p. 333).

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[18] Haigh also reports that "in some cases, an increase in defensive behavior was found to occur in the course of therapy" (3, p. 187).

[19] Analysis of the postinterview recordings also showed that the more successful clients were consciously more emotionally distressed about how they perceived themselves when they entered therapy; that is, their negative self-references during the first third were laden with affect more often than were those of the less successful members of the group (see Table 8).

The manifestation of increased negative perception of the counselor and increased reluctance to share and confide might be interpreted as "selective valves" favoring sensitivity to negatives in the counseling relationship in order to justify withdrawing and moving away from the counselor rather than toward him.

As indicated above, these clients defended themselves in still another way when threatened, by further dissociation of affect from perception of self. It is as if they were saying: "If I do not invest feeling in this concept of self which I perceive to be under attack, I cannot be hurt." This is similar to the self-protective mechanism, "alienation from self," which Horney describes, and which she ranks first in importance among the measures which individuals use to relieve tension (7, p. 177).

Client-centered therapy recognizes that the attainment of the real self is not easy, that some clients cannot face the totality of their experience even in the comparative safety of the treatment relationship. Such individuals revise their concept of self defensively by denying or distorting the symbolization of their experience and making more rigid their structure of self. They thus succeed in achieving a positive orientation to self once again and a somewhat reduced internal tension (20, pp. 193-194). Our postinterview recordings corroborate this since they show an increase in positive self-perception and an improved "outside the hour" feeling tone prior to closure of therapy for three of the four most defensive members of the group, all four of whom had been judged by the TAT analyst to have undergone least reorganization in therapy.[20] In this respect, our data too have demonstrated that clients exhibiting strong defensiveness sometimes evidence the same outward manifestations as do others who have not reorganized themselves defensively (3). The focused interview material indicates, however, that three of these same four clients left therapy with some awareness that they had not achieved a new, less vulnerable self.

Analysis of the postinterview recordings also shows that most of the subjects studied tended to have affect associated with self-perception to a greater degree in the last stage of treatment than when they first came to treatment. This suggests that these clients acquired a greater measure of personal integration as a consequence of their experience in treatment, so that there was less dichotomization of their intellectual, evaluatory faculties and the emotional, reactive components of their personalities. From this it would also seem legitimate to infer that, even in those cases where significant reorganization was not observed, client-centered therapy constituted an intense experience *of* the self, rather than *about* the self.

C. Some Additional Implications of This Study and Suggestions for Future Research

Our findings have demonstrated that meaningful personal documents can be secured which depict graphically and revealingly the counseling experience as perceived by the client. They have also demonstrated that measuring the client's verbal behavior, as it appears in such documents, is profitable.

The fact that the client documents contained many negative expressions about the counselor and the counseling experience and the fact that the members of this experimental group apparently did not feel obliged to provide testimonials to the efficacy of their treatment or to assert that the future promised to be problem-free as a result of their treatment would seem to verify

[20] The one individual who did not experience a restoration of positive self-perception and increased internal harmony was Client No. 7, who reported that therapy had made his problem "more acute" in that it had "impaired (his) ability to subvert it."

the writer's contention that frank reports can be obtained from clients when the circumstances surrounding the eliciting of these reports are sufficiently permissive.

The case for the loosely structured question also seems to have been supported in this research. While the evidence of this study does not indicate that a more restrictive type of questionnaire would not yield significant and pertinent material, it does indicate that the loosely structured question evokes a wide range of idiosyncratic, value-laden responses which tend to fall into patterns.

It would also appear that using the client as a participant in research on the psychotherapeutic process does not act to impede his treatment. This should embolden us to feel more secure in using methodology such as that which was employed here.

The findings derived from our data seem strongly to confirm client-centered theory that the individual behaves in accordance with his perceptions—that reality is, for each individual the field as perceived—that perception is steered by the needs of the individual organism.

The results of this research would also lead one to question the validity of a belief which is a basic tenet for many practitioners of psychoanalysis. Thus, while Schilder has stated that "A psychotherapy in which . . . negative transferences do not make their appearance is superficial, and analysis in which negative transference does not appear is a failure" (21, p. 158), the two members of this experimental group who exhibited "much" change following therapy did not manifest negative "transference" attitudes toward the therapist at all. Instead, they accepted the therapist as part and parcel of the total treatment experience and he served truly as an alter ego for them. Their postinterview recordings and their statements to the focus interviewer strongly suggest that these two most successful treatment cases were so preoccupied with the crucial process of self-exploration and self-reorganization that they were often unaware of the therapist's existence as a separate individual.

While the patterns uncovered in this study appear to have substantiated our hypothesis, the present investigation can only be considered as a pilot undertaking. Indeed, the generality of our findings is limited by virtue of the fact that the members of this experimental group came to therapy on referral. It would therefore be desirable to repeat this study with self-referred subjects to check the meaningfulness of the findings which emerged from this study.

As a consequence of this experiment, several ideas have glimmered through as to what may have tipped the balance in favor of limited self-exploration and defensive reorganization of self for the members of our "little" and "no" change groups. While these ideas (12) have appeared too infrequently in our data to assume statistical significance, they would seem to warrant further investigation if we are to develop hypotheses with respect to our therapeutic failures.

This study has presented a method for gaining insight into the meaning and impact of the therapeutic experience upon the client. It has also demonstrated, at least in regard to the group under study, that the patterns of feelings which the client holds toward himself, the patterns of attitudes which he exhibits toward the counselor, and his perception of the counseling experience bear meaningful relationships to the eventual outcome of therapy. Further research with larger groups of subjects is indicated to explore

these relationships in fuller detail, to uncover other significant elements in the client-counselor relationship crucial to the understanding of the therapeutic process, and to answer the provocative questions to which the data have led.

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(Accepted for publication November 29, 1953)

GEORGE BANTA PUBLISHING COMPANY, MENASHA, WISCONSIN